U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue Date: 18 May 2007

Case No. 2005-BLA-5086

In the Matter of:
B.B.,[1]
Claimant,

v.

CUMBERLAND RIVER COAL CO.,
Employer,
and
ARCH COAL, INC.
c/o UNDERWRITERS SAFETY & CLAIMS
Carrier,
and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:
Joseph Wolfe, Esq.,
On behalf of Claimant

Denise Davidson, Esq.,
On Behalf of Employer/Carrier

Brian Dougherty, Esq.,
On Behalf of Director

BEFORE: Thomas F. Phalen, Jr.
Administrative Law Judge

DECISION AND ORDER – AWARD OF BENEFITS

[1] Effective August 1, 1006, the Department of Labor directed the Office of Administrative Law Judges, the Benefits Review Board, and the Employee Compensation Appeals Board to cease use of the name of the claimant and claimant family members in any document appearing on a Department of Labor web site and to insert initials of such claimant/parties in the place of those proper names. In support of this policy change, DOL has adopted a rule change to 20 C.F.R. Section 725.477, eliminating a requirement that the names of the parties be included in decisions. Further, to avoid unwanted publicity of those claimants on the web, the Department has installed software that prevents entry of the claimant's full name on final decisions and related orders. This change contravenes the plain language of 5 U.S.C. 552(a)(2) (which requires the internet publication), where it states that "in ***each case*** the justification for the deletion [of identification] shall be explained fully in writing." (*emphasis added*). The language of this statute clearly prohibits a "catch all" requirement from the OALJ that identities be

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[2]

On August 16, 2004, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 48).[3] A formal hearing on this matter was conducted on July 27, 2006 in Hazard, Kentucky, by the undersigned Administrative Law Judge. (Tr. 1). All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

ISSUES[4]

The issues in this case are:

1. Whether this claim was timely filed;

2. Whether Claimant has pneumoconiosis as defined by the Act;

---

withheld. Even if §725.477(b) gives leeway for the OALJ to no longer publish the names of Claimants – 5 U.S.C. 552(a)(2) clearly requires that the deletion of names be made on a case by case basis.

I also strongly object to this policy change for reasons stated by several United States Courts of Appeal prohibiting such anonymous designations in discrimination legal actions, such as *Doe v. Frank,* 951 F. 2d 320 (11th Cir. 1992) and those collected at 27 Fed. Proc., L. Ed. Section 62:102 (Thomson/West July 2005). This change in policy rebukes the long standing legal requirement that a party's name be anonymous only in "*exceptional cases*." *See Doe v. Stegall*, 653 F.2d 180, 185 (5th Cir. 1981), *James v. Jacobson*, 6 F.3d 233, 238 (4th Cir. 1993), *and Frank* 951 F.2d at 323 (noting that party anonymity should be rarely granted)(*emphasis added*). As the Eleventh Circuited noted, "[t]he ultimate test for permitting a plaintiff to proceed anonymously is whether the plaintiff has a substantial privacy right which outweighs the customary and constitutionally-embedded presumption of openness in judicial proceedings." *Frank*, 951 F.2d at 323.

Finally, I strongly object to the specific direction by the DOL that Administrative Law Judges have a "mind-set" to use the complainant/parties' initials if the document will appear on the DOL's website, for the reason, *inter alia,* that this is not a mere procedural change, but is a "substantive" procedural change, reflecting centuries of judicial policy development regarding the designation of those determined to be proper parties in legal proceedings. Such determinations are nowhere better acknowledged than in the judge's decision and order stating the names of those parties, whether the final order appears on any web site or not. Most importantly, I find that directing Administrative Law Judges to develop such an initial "mind-set" constitutes an unwarranted interference in the judicial discretion proclaimed in 20 C.F. R. § 725.455(b), not merely that presently contained in 20 C.F.R. § 725.477 to state such party names.

[2] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[3] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

[4] At the hearing the Employer withdrew as uncontested the following issues: miner, post 1969 employment, responsible operator, insurance or self-insurer, dependency, and whether the miner's most recent period of cumulative employment of not less than one year was with the named responsible operator. (Tr. 17-18). In addition, the parties stipulated to at least seventeen years of qualifying coal mine employment. (Tr. 16).

3. Whether Claimant's pneumoconiosis arose out of coal mine employment;

4. Whether Claimant is totally disabled;

5. Whether Claimant's disability is due to pneumoconiosis;

6. Whether the Claimant has established a material change in conditions per §725.309(c),(d); and

7. Other issues which will not be decided by the undersigned but are preserved for appeal. (Item 18(b), DX 48).

(DX 48).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

B.B. ("Claimant") was born on February 2, 1948 and was fifty-eight years old at the time of the hearing. (DX 3; Tr. 23). He completed the eleventh grade. (DX 3). In September of 1973, Claimant married M.F.I., and they remained married at the time of the hearing. (DX 3; Tr. 16). They have one child, W.A., ("Child") who was born in July of 1989. (DX 3). At the time of the hearing, Child was still a student. (Tr. 18).

On his application for benefits, Claimant alleged he engaged in underground mine employment for nineteen years (DX 3), but the parties agreed at the hearing he worked only seventeen years. (Tr. 16). Claimant's last employment was as a coal miner, which ended in 1991. (DX 3; Tr. 16-17, 21). He worked as a beltman where he would take the car off the belt drivers and shovel belts. (DX 6). Claimant noted that he was awarded benefits for his Kentucky State Black Lung claim. (DX 3). According to Claimant, he no longer possesses the pulmonary capacity to return to his former coal mine employment. (Tr. 21).

Procedural History

Claimant filed his initial claim for benefits under the Act on February 3, 1992. (DX 1). This claim was denied by the District Director, Officer of Workers' Compensation. (DX 1). Claimant then appealed to the Office of Administrative Law Judges. The claim was denied by Administrative Law Judge Richard Malampy on July 23, 1993. (DX 1). Claimant then appealed to the Benefits Review Board ("Board") where the claim was affirmed by a decision on July 29, 1994. Claimant subsequently appealed to the United States Court of Appeals for the Sixth Circuit where they issued a decision on May 26, 1995 vacating the Board's finding and

remanded the claim back to the Office of Administrative Law Judges. The claim was again denied in May of 1996. (DX 1).

Claimant filed a subsequent claim on December 30, 1999. (DX 2). The District Director denied the claim on July 3, 2000. Claimant filed a request for reconsideration which was denied after the receipt of additional evidence on February 20, 2001. (DX 2). Claimant then filed another request for reconsideration, but after the examination of additional evidence, the District Director issued a denial on May 20, 2002 and administratively closed the claim.

On July 11, 2003, Claimant filed the instant claim for benefits under the Act. (DX 3). The Director issued a proposed decision and order – award of benefits on April 9, 2004. (DX 33). At the request of the Employer, a revised decision and order – award of benefits – was issued on May 11, 2004. (DX 37). Employer timely requested a formal hearing before the Office of Administrative Law Judges. (DX 48). The matter was transferred to this office on August 16, 2004. (DX 48).

Length of Coal Mine Employment

Claimant stated on his application that he engaged in coal mine employment for nineteen years. (DX 3). The Director determined that Claimant has at least seventeen years of coal mine employment. (DX 37). The parties also stipulated that the Claimant worked at least seventeen years in or around one or more coal mines. (Tr. 16). I find the record supports this stipulation (DX 3, 4, 5, 7; Tr. 16), and therefore, I hold that Claimant worked at least seventeen years in or around one or more coal mines.

Claimant's last coal mine employment was in the Commonwealth of Kentucky (DX 1, 3, 7). Therefore, the law of the Sixth Circuit is controlling.[5]

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. The District Director identified Cumberland River Coal Co. ("Employer") as the putative responsible operator due to the fact that it was the last company to employ Claimant for a full year. (DX 37). Employer does not contest this issue and it is supported by the evidence of record. (Tr. 16; DX 7). Therefore, I find Cumberland River Coal Co. is correctly identified as the responsible operator.

Timeliness

Under § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is

[5] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001). In addition, the court stated:

> The three-year limitations clock begins to tick the first time that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of a miner's claim or claims, and, pursuant to *Sharondale*, the clock may only be turned back if the miner returns to the mines after a denial of benefits. There is thus a distinction between premature claims that are unsupported by a medical determination, like Kirk's 1979, 1985, and 1988 claims, and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period. [Footnote omitted.] Three years after such a determination, a miner who has not subsequently worked in the mines will be unable to file any further claims against his employer, although, of course, he may continue to pursue pending claims.

Id.

However, in a subsequent opinion, the Sixth Circuit adopted a position which states that when a doctor determines a miner is totally disabled due to pneumoconiosis, and a subsequent judicial finding holds that the claimant is not totally disabled due to pneumoconiosis, the medical determination must be a misdiagnosis and cannot "equate to a 'medical determination' under the statute." *Peabody Coal Co. v. Director, OWCP,* 48 Fed. Appx. 140 at 146 (6th Cir. Oct. 2, 2002)(unpub.). In summary, "if a miner's claim is ultimately rejected on the basis that he does not have the disease, this finding necessarily renders any prior medical opinion to the contrary invalid, and the miner is handed a clean slate for the statute of limitation purposes." *Id.*

In an unpublished opinion arising in the Sixth Circuit, *Furgerson v. Jericol Mining, Inc.*, BRB Nos. 03-0798 BLA and 03-0798 BLA-A (Sept. 20, 2004) (unpub.), the Benefits Review Board held that *Kirk*, 264 F.3d 602 is controlling and directed the administrative law judge in that case to "determine if [the physician] rendered a well-reasoned diagnosis of total disability due to pneumoconiosis such that his report constitutes a 'medical determination of total disability due to pneumoconiosis which has been communicated to the miner'" under § 725.308 of the regulations.[6]

Here, Employer has pointed to no evidence that a physician offered any opinion to the Claimant, much less a well reasoned opinion, that he was totally disabled due to pneumoconiosis. Furthermore, in Employer's brief, they did not even address the issue. Under §

[6] I find that when *Kirk*, *Peabody Coal*, and *Ferguson* are in pari materia, the following principal of law emerges: In order that a communicated diagnosis of total disability of pneumoconiosis be sufficient to bar a black lung claim on the basis of timeliness, the communicating physician's report must be both well reasoned and well documented. Nevertheless, while I have applied this standard in the instant case, I note that this claim would not be barred under § 725.308(a) under any of the above cases.

725.308(c), there is a presumption that every claim is timely filed. As Employer has presented no contrary evidence on this issue, I find this claim to be timely filed.[7]

NEWLY SUBMITTED MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under Section 725.414(a)(2)(i) and (3)(i) or Section 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of Sections 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under Section 725.414. § 725.406(b).

An administrative law judge is not permitted to arbitrarily pick what evidence is to be admitted into the record under § 725.414 in a claim. *Brasher v. Pleasant View Mining Co.*, 23 B.L.R. 1-141 (2006). However, since the implementation of the New Regulations,[8] parties have continued to "submit" multiple pieces of evidence before the hearing, the inclusion of which would exceed §725.414. To keep the parties within the evidentiary limitations of § 725.414, the Office of Administrative Law Judges created an Evidence Summary Form. Here, parties are given the opportunity to tell the administrative law judge exactly what medical evidence they want considered, even though they may have "submitted" evidence outside the scope of § 725.414. This allows the administrative law judge to determine what is officially in the record for consideration under the New Regulations, and what is not. This seems only fair, as frustrations would mount if an administrative law judge randomly picked from the multiple reports, x-rays, and other objective tests submitted by the parties to align the evidence in accordance with § 725.414.

Furthermore, as evidence often comes to light just before the hearing, an administrative law judge may permit the submission of evidence (rebuttal, or otherwise) post-hearing.

---

[7] Furthermore, it is the Employer's burden to show that a medical determination of total disability due to pneumoconiosis has been *communicated* to the miner under § 725.308(c)(*emphasis added*); *See also Tennessee Consolidated Coal Company,* 264 F.3d 602 (where the court notes the statute of limitations clock begins to run when the miner is first told by a physician he has pneumoconiosis). Employer has shown no evidence that any physician communicated his findings to Claimant.

[8] Located at 20 C.F.R. §§ 718, 722, 725 and 726.

Oftentimes, however, a party will have already submitted a summary evidence form which could not possibly include rebuttal evidence that does not exist. Therefore, some administrative law judges make it a policy to allow for the submission of Amended Summary Evidence Forms when this instance arises.[9] This allows for both proper rebuttal and proper designation under § 725.414.

Recently, many parties have voiced complaint about not knowing what evidence is going to come in the record, and what evidence will be excluded until they receive the issued opinion.[10] It is not the job of the office of administrative law judges to educate attorneys on the admissibility limitations under § 725.414.[11] Nevertheless, parties are afforded the opportunity to properly designate their evidence on the Summary Form and have the opportunity to amend the Summary Form should the record be left open for the submission of additional evidence. Furthermore, there is nothing stopping parties from contacting our office to ask questions on the proper use of the Summary Evidence Form.[12] In fact, many judges, including the undersigned, actually encourage parties to contact our office with questions on this issue in our pre-hearing orders. This type of advice by the administrative law judge's staff provides general guidelines to simply help the parties properly designate their evidence.

Thus, oftentimes a Summary Evidence Form may appear "incomplete," i.e., have empty designations. However, simply because a party may have previously "submitted" evidence which *could* fill this gap, an administrative law judge should not be cast in the role of arbitrarily assembling evidence under § 725.414 for either party, especially when the party was given an opportunity to do so.[13] Again, it is not the duty of a judge to put a case together for a party – but rather to adjudicate the case before him or her in accordance with the law.

Claimant selected Dr. Randolph Forehand to provide his Department of Labor sponsored complete pulmonary evaluation. (DX 12). Dr. Forehand conducted the examination on July 29, 2003. (DX 13). I admit Dr. Forehand's report under Section 725.406(b).

Claimant completed a Black Lung Benefits Act Evidence Summary Form. (CX 5). Claimant designated Dr. Patel's March 29, 2004 x-ray reading (CX 1),[14] and Dr. Alexander's May 4, 2006 x-ray reading as initial evidence. (CX 4).[15] As rebuttal evidence, Claimant

---

[9] Of course, permission to do this must be granted at the hearing.

[10] Such was the case here. *See Tr.* 13-14. Employer stated it is "difficult to know if we've made our case, or if we've had an opportunity to cure any particular defects." (Tr. 13).

[11] I would like to note that these "New Regulations" (as they are commonly referred to), at 20 C.F.R. §§ 718, 722, 725 and 726 were amended in January of 2001 and have been in effect for over six years. Their validity was upheld on August 9, 2001, by the United States District Court for the District of Columbia. While the limitation rule under § 725.414 is unique to this area of practice, it is an attorney's duty to educate himself on the rules of law in the area in which he practices.

[12] Many individuals, including *pro se c*laimants, often call our office for guidance on this issue.

[13] I note attorneys and *pro se* parties may appear to be receiving different treatment in understanding and interpreting the law.

[14] *See Supra* n. 19.

[15] First, Claimant's Summary Evidence Form neither correlates nor corroborates evidence that was admitted at the hearing. At the hearing, Claimant designated as CX 4 a re-reading of an x-ray dated July 29, 2003 by Dr. Alexander. (Tr. 7). There, it was stated that as CX 4 duplicates DX 18, it was withdrawn from evidence. (DX 7). Claimant stated on June 16, 2006 through correspondence that he intended to submit an original x-ray report by Dr.

submitted Dr. Alexander's reading of the July 29, 2003 x-ray. (DX 18).[16] Claimant designated the PFT studies dated February 26, 2001 and March 29, 2004 conducted by Dr. Rasmussen as initial evidence. (CX 1, 2). Claimant also designated Dr Rasmussen's ABGs conducted on February 26, 2001 and March 29, 2004 as initial evidence. In terms of medical reports, Claimant designated the reports of Dr. Rasmussen dated February 26, 2001 and March 29, 2004. (CX 1, 2). Finally, Claimant designated treatment records from Mountain Comprehensive Corporation contained at CX 3. (CX 3). Claimant's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3). Therefore, with the exception of the x-ray dated May 4, 2006, I admit Claimant's designated evidence in its Summary Form.

Employer completed a Black Lung Benefits Act Evidence Summary Form. (EX 9). As initial evidence, Employer designated the x-ray readings of Dr. Wiot dated September 18, 2003 and November 25, 2005. (DX 19; EX 4). As rebuttal evidence of the Department sponsored x-ray, Employer submitted the reading of Dr. Wiot dated September 18, 2003. (DX 17). Employer also submitted a rehabilitative report by Dr. Wiot. (EX 7).[17] Employer submitted no PFT studies, but submitted the ABG study conducted by Dr. Jarboe dated September 18, 2003. (DX 15).

Under the medical reports, Employer submitted as initial evidence the deposition of Dr. Jarboe dated February 12, 2004 (EX 3) where he testified regarding his September 18, 2003 examination of Claimant, his subsequent report dated September 24, 2003, as well as his review of Dr. Forehand's report dated July 29, 2003. The initial report of the September 18, 2003 examination is attached to the deposition as deposition exhibit one.[18] Employer also submitted as initial evidence the February 16, 2006 deposition of Dr. Jarboe (EX 6) where he discussed his previous deposition, his report of July 19, 2004 where he reviewed Dr. Forehand's report of July

---

Alexander dated May 27, 2006 of a May 4, 2006 x-ray at the hearing. He listed this x-ray as "CX 4" on his summary evidence form. However, Claimant made no such motion for admission at the hearing, as he said he would through his letter. Furthermore, Employer raised a motion to strike any such reference to the May 4, 2006 x-ray over two weeks before the hearing. Employer stated that the May 4, 2006 x-ray was not on file with the U.S. Department of Labor and presented a copy of a Department of Labor letter stating so. Rather than present evidence to the contrary and challenge Employer's motion, Claimant apparently chose to submit a reading of the July 29, 2003 x-ray by Dr. Alexander dated December 30, 2003, which is now specified as CX 4. As such, I shall consider this x-ray reading as Claimant's initial evidence under § 725.414. Furthermore, since the May 4, 2006 x-ray was never submitted as evidence at the hearing, and Claimant presented no evidence to contradict Employer's evidence that the x-ray was not on file with the Department of Labor, I hereby grant Employer's motion to strike any reference to the May 4, 2006 x-ray.

[16] A rebuttal of the Department sponsored x-ray is permissible under *Sprague v. Freeman United Coal Mining Co*., BRB No. 05-1020 BLA (Aug. 31, 2006)(unpublished). In this case, the Board held that "rebuttal" evidence need only refute "the case" presented by the opposing party rather than refute a particular piece of evidence. Specifically, the Board held that the Administrative Law Judge should have allowed Claimant's positive x-ray rereading to "rebut" a positive x-ray interpretation underlying the § 725.406 pulmonary evaluation.

[17] The only x-ray submitted by the Employer which was undermined by the Claimant would be the July 29, 2003 x-ray, which was read on September 18, 2003 by Dr. Wiot. Therefore, I shall only consider that portion of his rehabilitative report that discusses this x-ray. All other x-rays submitted by the Employer were not undermined by Claimant.

[18] Along with the medical report of Dr. Jarboe, Employer has attached Dr. Jarboe's x-ray, PFT, and ABG. As admitting the x-ray would cause Employer to exceed the evidentiary limitations of § 725.414, it is excluded. However, the admission PFT result is within the evidentiary limitations. Therefore, under the logic articulated by the Board under *Wells v. Arch of Kentucky, Inc.,* BRB No. 05-0705 BLA (unpublished), his medical report, along with his PFT results, shall be considered. The ABG results were already submitted.

29, 2003, Dr. Rasmussen's report of March 29, 2004 (EX 2), his report dated September 24, 2003, PFT studies and ABG studies dated from March 17, 1992 through March 29, 2004 (EX 5), along with reports of a chest x-ray and report of a CT scan of the chest dated October 31, 1994. (DX 1). Finally, Employer submitted again as initial evidence another deposition of Dr. Jarboe dated June 28, 2006 where he reviewed Dr. Rasmussen's report dated February 26, 2001 along with his previous reports of September 24, 2003, July 19, 2004, and February 16, 2006. (EX 8). For purposes of § 725.414, I shall consider the last two depositions as supplemental to the first and read them as the complete testimony of Dr. Jarboe.

Rehabilitative evidence is only allowed when rebuttal evidence is presented that tends to undermine the conclusion of a physician who prepared one of the initial medical reports. A rehabilitative report can only be submitted from the physician who prepared the original medical report explaining his or her conclusion in light of the rebuttal evidence. § 725.414(a)(2)(ii) and 3(ii). Here, Employer submits the report of Dr. Jarboe dated July 19, 2004 as rehabilitative evidence. (EX 2). However, Claimant submitted no rebuttal evidence of any of Dr. Jarboe's reports/depositions. Furthermore, none of Claimant's initial medical reports specifically attack the report of Dr. Jarboe. As such, I find Employer is not permitted to submit the July 19, 2004 report of Dr. Jarboe as rehabilitative evidence.

Finally, Employer submitted a CT scan report dated October 31, 1994 located at DX 1 as other medical evidence under § 718.107. Because this report was part of the initial claim, and this is a subsequent claim that falls under § 725.309, evidence from the prior claim may not be considered until Claimant has proven a change of condition. Therefore, the CT scan report submitted by the Employer shall not be considered unless Claimant proves a change of condition.

As Employer's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414(a)(3), with the exceptions of Dr. Jarboe's July 19, 2004 report and the October 31, 1994 CT scan, it is admitted for consideration in this claim.

X-RAYS[19]

Exhibit	Date of X-Ray	Date of Reading	Physician/Qualification	Film Quality	Interpretation
DX 13	7/29/03	7/29/03	Forehand / B-Reader[20]	1	1/0ps

[19] On June 14, 2006, Employer submitted a motion to strike any reference to the x-ray dated February 26, 2001. This x-ray was not submitted as evidence under § 725.414 – so this motion is moot. Employer also submitted a motion to strike any reference to the x-ray dated March 29, 2004 as the x-ray film was not filed with the United States Department of Labor and was thus unavailable for rebuttal. However, Claimant's correspondence, which was copied to the undersigned, indicated the film was mailed to Claimant on July 28, 2006. Employer made no objection to the admission of this x-ray at the hearing, subject to their availability for rebuttal post hearing. (Tr. 8). Employer filed an x-ray report by of this x-ray in September by Dr. Wiot, over two months after the hearing. However, I specifically stated at the hearing that should either party wish to submit additional evidence beyond what was designated in their summary evidence form, they needed to submit an amended summary evidence form to include the new evidence for consideration. (Tr. 9). Employer did not do this – thus the Employer's reading of the March 29, 2004 x-ray is not admitted.

[20] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health

DX 17	07/29/03	09/18/03	Wiot / B-Reader, BCR[21]	1	Negative
DX 18 / CX 4	07/29/03	12/30/03	Alexander / B-Reader, BCR	1	1/1pp
DX 19	09/18/03	10/21/03	Wiot	1	Negative
CX 1	03/29/04	03/30/04	Patel / B-Reader, BCR	1	1/2st
EX 4	11/25/05	02/22/06	Wiot	3	Negative

PULMONARY FUNCTION TESTS

Exhibit/ Date	**Co-op./ Undst./ Tracings**	**Age/ Height[22]**	**FEV_1**	**FVC**	**MVV**	**FEV_1/ FVC**	**Qualifying Results**	**Comments**
CX 2 2/26/01	---	53/ 67	1.83 1.94*	3.01 3.06*	69 77*	61 63*	Yes Yes	Moderate, irreversible obstructive ventilatory impairment.
DX 13 7/29/03	Good/ Good/Yes	55/ 66	1.57 1.62*	2.86 2.86*	56 61*	55 56*	Yes Yes	
EX 3 9/18/03	Good/ Good/Yes	55/ 67	1.28 1.35*	2.47 2.53*	50 58*	52 53*	Yes Yes	Moderate restrictive, very severe obstructive impairment. Reduced FVC due to severe air trapping.
CX 1 3/29/04	---	56/ 68	1.50 1.53*	2.74 2.74*	-- --	55 56*	Yes No	Severe, irreversible obstructive ventilatory impairment.

* Indicates Post-Bronchodilator Values

ARTERIAL BLOOD GAS STUDIES

Exhibit	**Date**	**pCO_2**	**pO_2**	**Qualifying**	**Comments**
CX 2	2/26/01	39.0 43.0*	64.0 56.0*	No Yes	

reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

[21] A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[22] The fact finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). As the three reports show varying heights from 66-68 inches, I will use the midpoint and find the miner's height to be 67 inches.

DX 13	7/29/03	35.0 34.0*	57.0 51.0*	Yes Yes	
DX 15	9/18/03	41.8	69.2	No	Marked carboxy hemoglobin compatible with smoking up to two packs of cigarettes a day.
CX 1	3/29/04	40.0 42.0*	62.0 59.0*	No Yes	

*post exercise

Narrative Reports

Dr. Randolph Forehand examined Claimant on July 29, 2003. (DX 13). Dr. Forehand considered the following: an age of fifty-five years; an EKG report showing no acute changes; an employment history of nineteen and a half years as a beltman; family history of high blood pressure, heart disease, diabetes, and emphysema; a personal history of frequent colds, pneumonia, attacks of wheezing (all since 1988), chronic bronchitis (since 1990), and arthritis; a smoking history of thirty-six pack years (1967-current); a physical examination which revealed crackles present at the bases; an x-ray (1/0ps), a PFT (obstructive ventilatory pattern), and an ABG (arterial hypoxemia). After considering the evidence above,[23] Dr. Forehand diagnosed clinical pneumoconiosis and chronic bronchitis.[24] He also noted that Claimant's respiratory impairment was significant – resulting in an insufficient ventilatory and oxygen transport capacity, which renders Claimant totally and permanently disabled. Thus, Claimant could not return to his former coal mine employment. According to Dr. Forehand, this is the result of both a lengthy smoking history and exposure to coal mine dust. However, had Claimant never worked in a coal mine, Dr. Forehand opined that Claimant's respiratory impairment would not be of the same degree.

Dr. Rasmussen examined Claimant on February 26, 2001 and submitted a report. (CX 2). Dr. Rasmussen considered the following: an age of fifty-three years; personal history of chronic productive cough, daily wheezing in the mornings and with exertion, shortness of breath at night, a cardiac catheterization, chronic bronchitis, attacks of wheezing, pneumonia in 1988 and severe dyspnea in 1995 or 1996; physical examination revealing normal chest expansion with moderately reduced breath sounds and scattered rhonchi (mostly on the left), and a prolonged expiratory phase with forced respirations; smoking history of thirty-six pack years; employment history of working in the coal mines between 1973 and 1991 (Dr. Rasmussen considered seventeen years), primarily and last working as a belt man – which required him to shovel, lift heavy objects, break rock, and carry rock dust bags up to eighty pounds up to eighty or ninety feet;[25] objective tests including an x-ray (1/0),[26] a PFT (revealing moderate, irreversible obstructive ventilatory defect), ABG (minimal hypoxia); treadmill exercise in which Claimant

[23] Dr. Forehand specifically noted that he relied upon Claimant's personal history, physical examination, x-ray, and ABG study in coming to this conclusion regarding clinical pneumoconiosis.
[24] The diagnosis of chronic bronchitis was based upon claimant's history, physical examination, and PFT study.
[25] Dr. Rasmussen considered this to be heavy manual labor.
[26] This x-ray was read by Dr. Patel, who is both a BCR and a B-reader. However, the x-ray was not submitted as evidence under the limitations of § 725.414.

retained a breathing reserve of only thirty liters, and exhibited moderate impairment in oxygen transfer and was moderately hypoxic. Dr. Rasmussen diagnosed a moderate loss of lung function which rendered Claimant totally disabled. He opined that this impairment was the result of clinical pneumoconiosis, which resulted from a lengthy coal mine employment as well as cigarette smoking.

Dr. Rasmussen examined Claimant on March 29, 2004 and submitted a report. (CX 1). Dr. Rasmussen considered the following: an age of fifty-six years; family history of hypertension, heart disease, diabetes, emphysema, and black lung; personal history of childhood pneumonia, frequent colds, and a cardiac catheterization in the late 1990's; physical examination of a normal chest expansion, but the breath sounds were moderately to markedly reduced with scattered rhonchi and rales on both sides (greater on the right side), and prolonged expiratory phase with forced expirations; a treadmill exercise study that showed Claimant retained only a breathing reserve of eighteen liters, indicating significant ventilatory limitation to exercise and a moderate impairment in oxygen transfer; a personal history of chronic, productive cough with trouble breathing at night, wheezing with exertion and at night; employment history as a coal miner from 1966 to 1997 (Dr. Rasmussen noted seventeen working years) where he worked as a general inside laborer, belt man, rock duster, and last working as an inside laborer;[27] a smoking history of roughly thirty-eight pack years, with Claimant recently cutting down to half a pack a day;[28] objective tests including an x-ray (1/0),[29] a PFT study (severe, irreversible obstructive ventilatory impairment with a normal lung capacity), an ABG study (moderate resting hypoxia), and an EKG (regular sinus rhythm). After considering all the above evidence, Dr. Rasmussen opined that the studies indicated a marked loss of lung function resulting from clinical pneumoconiosis. He noted that the disabling lung disease was the result of Claimant's lengthy smoking habit as well as coal dust exposure. This pulmonary disability, in his opinion, keeps Claimant from having the capacity to return to his former coal mine employment.

Dr. Jarboe examined Claimant on September 18, 2003 and submitted a report. (DX 15).[30] He considered the following: an age of fifty-five years; nineteen years of coal mine employment, ending in 1991 because the mine was shut down; the last sixteen years were spent as a belt man where Claimant shoveled, greased, watch the belt drive, and rock dusted (it is noted Claimant did not wear a mask or respirator); symptomatology: unable to lie down flat because mucus will fill up in his chest and he has to get up and cough for two or three hours to get the mucus out. During this time, Claimant is short of breath. Walking 500 feet will also cause shortness of breath, which becomes worse with humidity. Claimant estimated he will raise four to five ounces of mucus daily and suffers from daily wheezing (his wife stopped using hairspray because it makes him short of breath); personal history (pneumonia twice as a child, but no asthma); a smoking history of thirty-six pack years; physical examination (slight decease in the expiratory breath sounds over the upper zones with bibasilar expiratory wheezes heard);

---

[27] Dr. Rasmussen describes that Claimant had to carry up to fifty pounds of rock dust bags up to 100 feet, shoveled the belt, and helped to make belt and power moves. Thus, he considered this to be extremely heavy manual labor.

[28] This smoking history varies a little with the one provided in the previous examination. In CX 2, Claimant reported to Dr. Rasmussen that he had quit smoking in March of 2000.

[29] This x-ray was read by Dr. Patel, who as noted above, is both a BCR and a B-reader.

[30] This report has been admitted because it was attached to the deposition. As noted *infra*, the Board has held this to be proper designation under § 725.414. As such, Dr. Jarboe's report will be cited as DX 15, where the original report is located.

objective tests including x-ray (negative for pneumoconiosis), PFT (severe airflow obstruction with no response to dilators – indicating severe pulmonary emphysema), and ABG (mild to moderate emphysema). Based on this data, Dr. Jarboe diagnosed chronic bronchitis and severe pulmonary emphysema. He stated there was not "sufficient evidence to make a diagnosis of coal workers' pneumoconiosis." He based this on his own negative reading, and Dr. Forehand's reading of 1/0 which to Dr. Jarboe indicated Dr. Forehand "considered a negative diagnosis."

Dr. Jarboe also noted two reasons he believed any pulmonary condition was the result of cigarette smoking and not coal dust exposure. First, he noted the absence of radiographic evidence in his x-ray and Dr. Forehand's and stated that the degree of pulmonary emphysema present in coal miners is proportionate to dust retention in the lungs. Second, Claimant has a large increase in residual volume. He stated, "[w]hile it is known that coal dust inhalation can cause minor increase in residual volume, increases of this magnitude are nearly always caused by pulmonary emphysema."

Dr. Jarboe testified three times through depositions on February 12, 2004, February 16, 2006, and June 28, 2006. (EX 3, 6, 8). In his first deposition, Dr. Jarboe considered his own September 18, 2003 examination of Claimant, his subsequent report dated September 24, 2003, and a review of Dr. Forehand's report dated July 29, 2003. Dr. Jarboe's examination consisted of Claimant's history, smoking history (pack a day from the age of nineteen), physical examination, chest x-ray, PFT, and ABG. Based on this evidence, as well as Dr. Forehand's report dated July 29, 2003, Dr. Jarboe opined that Claimant suffers from chronic bronchitis, severe pulmonary emphysema, and possibly angina pectoris. He based this on what he called "a negative x-ray reading by Dr. Forehand" which was read 1/0. Thus, he opined there was no radiographic evidence of the disease. Furthermore, Dr. Jarboe opined that Claimant's pulmonary condition was the result of smoking and not coal dust exposure. He based this on two things. First, Claimant's testing demonstrated a well preserved total lung capacity. Second, Claimant has a "markedly increased residual volume" (180% of predicted). Even though coal dust can cause an increase in residual volume, Dr. Jarboe noted that an increase of this magnitude is "nearly always" caused by pulmonary emphysema. Here, he stated that this was caused by smoking cigarettes, which is evidenced by his own and Dr. Forehand's negative x-ray readings. Also, Dr. Jarboe testified that Claimant's chronic bronchitis is not related to Claimant's coal mine work. Rather, he opined that because Claimant had been out of the coal mines since 1990, any sign of pneumoconiosis would have shown up long before now. He specifically stated "[c]oal miners an cough because of their dust exposure, but nearly all of them will tell you that after six months to at most a year, most of the time the cough will clear up once the dust is cleared out of their lungs." Dr. Jarboe did however feel as though Claimant was totally and permanently disabled from a pulmonary perspective.

In his second deposition dated February 16, 2006, Dr. Jarboe stated he continued to hold the same opinion as before: that Claimant does not suffer from a coal dust induced lung disease. (EX 6). He discussed his previous deposition, the evidence contained within his report of Claimant's physical exams dated September 24, 2003 and July 19, 2004, Dr. Forehand's report of July 29, 2003, Dr. Rasmussen's report of March 29, 2004, CT scan taken on October 31, 1994,[31] and various PFTs and ABGs taken from March 17, 1992 – March 29, 2004. Mostly, he

[31] This CT scan is contained in DX 1.

noted the changes/similarities between the PFTs dated in 1992 and the most recent tests. Dr. Jarboe specifically stated Claimant's "FEV1 in March of 1992 was 1.76 liters … and in March of 2004, it was 1.50 liters." He opined that such a decrease would be expected in any individual simply because of aging. He attributed Claimant's "fairly severe emphysema" to smoking because there was no dust in his lungs on the CT scan. Dr. Jarboe also compared his ABG with those of Drs. Rasmussen and Forehand to demonstrate Claimant suffers from an "asthmatic like problem."

In the final deposition dated June 28, 2006, Dr. Jarboe reviewed Dr. Rasmussen's report dated February 26, 2001, along with his own personal reports dated September 24, 2003, July 19, 2004, and the February 16, 2006 deposition. (EX 8). Considering all the evidence, Dr. Jarboe still believed Claimant's severe pulmonary impairment was caused by, aggravated by, or substantially contributed to by the inhalation of coal dust. He opined that Claimant's pulmonary condition was the result of a combination of cigarette smoking and some associated asthma. To support this finding – he noted the reversibility of the airflow obstruction, as it was seen in Dr. Rasmussen's May 23, 2000 PFT., where the FEV1 improved by twelve percent. He also noted that his personal examination, as well as Dr. Dahhan's March 2000 examination, showed an elevation in lung volumes, which would be indicative of emphysema. While he stated emphysema can be found as a result of coal dust exposure – he noted that it is in proportion to the degree of dust retention in the lungs. As the 1994 CT scan and the recent x-rays were negative, Dr. Jarboe concluded that Claimant's significant pulmonary emphysema is the result of a lengthy smoking history.

Treatment Records

Contained at CX 3 are treatment records from the Mountain Comprehensive Corporation. Specifically, there are five PFT results, all of which are interpreted by Dr. Mahmood Alam.[32] However, the tests results submitted to this court do not contain the three tracings as required by § 718.103(b). As such, I find these PFT results are not in compliance with the Act and are entitled to no weight.

Also contained within the treatment records are an EKG and an occupational history form filled out by the Claimant.

Smoking History

At the hearing, Claimant indicated that he still smoked, but had recently cut down to half a pack a day. (Tr. 22). He also indicated that he began smoking around the age of eighteen. (Tr. 24). Dr. Forehand indicated in his 2003 examination that Claimant smoked thirty-six pack years and continued to smoke. (DX 13). In his 2001 examination, Dr. Rasmussen noted Claimant had smoked for thirty-six pack years. (CX 2). Three years later in 2004, Dr. Rasmussen indicated in his second examination that Claimant had a thirty-eight pack year smoking history, with Claimant recently cutting down to half a pack. After weighing all the evidence, I find Claimant smoked thirty-eight pack years as of 2004 and continued to smoke at a pace of half a pack a day.

[32] The tests were conducted on the following dates: August 2, 2004, August 30, 2004, October 28, 2004, November 30, 2004, and April 18, 2006.

DISCUSSION AND APPLICABLE LAW

Claimant's claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section;

2. Has met the requirements for entitlement to benefits by establishing that he:

   (i) Has pneumoconiosis (see § 718.202);

   (ii) The pneumoconiosis arose out of coal mine employment (see § 718.203);

   (iii) Is totally disabled (see § 718.204(c));

   (iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Subsequent Claim

The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248 (10th Cir. 1990); *Orange v. Island Creek Coal Compamy*, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). The amended version of § 725.309 dispensed with the material change in conditions language and implemented a new threshold standard for the claimant to meet before the record may be reviewed *de novo*. Section 725.309(d) provides that:

> If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part, the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see § 725.202(d) miner. . .) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:

> (1) Any evidence submitted in conjunction with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
>
> (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of the subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.
>
> (3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence establishes at least one applicable condition of entitlement. . . .
>
> (4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

§ 725.309(d) (April 1, 2002).

Claimant's prior claim was denied after it was determined that he failed to establish any of the elements of entitlement. (DX 2). Consequently, the Claimant must establish, by a preponderance of the newly submitted evidence, at least one applicable condition of entitlement previously adjudicated against him.

Total Disability

Claimant may establish a material change in conditions by demonstrating that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under § 718.204(b), all relevant probative evidence, both like and unlike must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

There is no evidence of complicated pneumoconiosis in the record. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of pulmonary function studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. Also, in *Crappe v. U.S. Steel Corp*., 6 B.L.R. 1-476 (1983), the Board held that a non-conforming PFT may be entitled to probative value where the study was not accompanied by statements of miner cooperation and comprehension and the ventilatory capacity was above the table values. This is because any deficiency in cooperation and comprehension could only result in higher results.

The first PFT contained in the record was conducted on February 26, 2001. The results of this study produced qualifying results pre and post bronchodilator. The second PFT conducted on July 29, 2003 produced qualifying results pre and post bronchodilator. The third PFT conducted on September 18, 2003 produced qualifying results pre and post bronchodilator.[33] The last PFT submitted by the parties produced qualifying results, but rose barely above qualifying after bronchodilators were administered. As seven of the eight submitted PFTs produced qualifying results, I find that Claimant has established total disability under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) if the results of ABGs meet the requirements listed in the tables found at Appendix C to Part 718. The ABG conducted on February 26, 2001 produced non-qualifying results at rest, but the results became qualifying post exercise. The second ABG conducted on July 29, 2003 produced qualifying results both pre and post exercise. The third ABG conducted on September 18, 2003 produced qualifying results, but was conducted without exercise. The final ABG conducted on March 29, 2004 did not produce qualifying results at rest, but were qualifying post exercise. Considering all the ABG evidence, there are four qualifying results (all post exercise studies produced qualifying results) and three non qualifying results. I therefore find that Claimant has established the existence of total disability under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine employment or comparable gainful employment. Claimant's usual coal mine employment included working primarily working as a belt man – which required him to shovel, lift heavy objects, break rock, and carry rock dust bags up to eighty pounds up to eighty or ninety feet. (DX 1-3, 6; Tr. 20-21; CX 2). This continued until Claimant left the coal mining industry in 1991.

[33] I note that even if Employer *intended* to leave this PFT from the record and I had done so, I still would have found Claimant had proved total disability under § 718.204(b)(2)(i).

Dr. Forehand opined that Claimant was totally disabled from a pulmonary standpoint based on an accurate employment history, objective tests, and a physical examination. Specifically, Dr. Forehand stated the impairment showed an insufficient ventilatory and oxygen transport capacity. As Dr. Forehand offered a strong conclusion based upon the objective evidence he considered, I find his opinion on the issue of total disability to be well reasoned and well documented. Thus, I accord his opinion probative weight.

Dr. Rasmussen examined the Claimant twice. In the first examination, Dr. Rasmussen stated that Claimant suffered from a moderate pulmonary impairment, but in light of Claimant's job requiring heavy manual labor, he opined Claimant was totally disabled. This diagnosis was based upon objective evidence (ABG, PFT, and treadmill exercise test), a physical examination, and an accurate employment history. As Dr. Rasmussen offered a strong conclusion based upon the objective evidence he considered, I find his opinion on the issue of total disability to be well reasoned and well documented.[34] Thus, I accord his opinion probative weight.

In the second examination, Dr. Rasmussen again stated that based upon the new objective evidence and physical examination, that Claimant was still totally disabled from a respiratory standpoint. He considered the ABG, PFT, treadmill exercise test, and physical examination in rendering this opinion. As Dr. Rasmussen offered a strong conclusion based upon the objective evidence he considered, I find his opinion on the issue of total disability to be well reasoned and well documented. Thus, I accord his opinion probative weight.

Dr. Jarboe, a Board-certified Internist, Pulmonologist, and B-reader, testified through deposition three times regarding the issue of total disability and submitted a medical report. Each time, he found Claimant to be totally disabled by a pulmonary impairment. While Dr. Jarboe relied upon numerous studies and tests which were outside the scope of § 725.414 at this point, those he did rely on affirmed his findings on total disability.[35] Specifically, Dr. Jarboe relied upon the PFT results obtained from Dr. Rasmussen's February 26, 2001 and March 29, 2004 examinations, his own PFT and physical examination, along with the PFT conducted by Dr. Forehand. As Dr. Jarboe relied upon objective evidence in drawing his conclusion, I find his opinion to be well reasoned and well documented. Thus, I accord his opinion probative weight.

Accordingly, taken as a whole, the medical narrative evidence supports a finding of total pulmonary disability. Thus, I find that Claimant has established total pulmonary disability under § 718.204(b)(iv).

Reviewing the evidence considered under § 718.204(b) as a whole, I find that Claimant has established that he is totally disabled due to a respiratory or pulmonary impairment under subsection (b)(2)(i). Since the newly submitted evidentiary record establishes total disability, and this evidence differs "qualitatively" from the evidence previously submitted, Claimant's subsequent claim will not be denied on the basis of the prior denial. As a result, I will consider the entire record *de novo* to determine ultimate entitlement to benefits.

[34] Even though the x-ray he considered in 2001 was not admitted under § 725.414 – Dr. Rasmussen did not rely on it to diagnose total disability. Therefore, its consideration in this instance does not affect the weight of his opinion.
[35] The evidence he considered outside of § 725.414 will be discussed *infra*.

PRIOR MEDICAL EVIDENCE[36]

X-RAYS

Exhibit	Date of X-Ray	Date of Reading	Physician/Qualification	Interpretation
DX 2	3/15/2000	3/15/2000	Dr. Patel / B-reader BCR	1/0
DX 2	3/15/2000	4/24/2000	Dr. Sargent / B-reader BCR	Negative
DX 2	3/15/2000	5/11/2000	Dr. Barrett / B-reader, BCR	Negative
DX 2	3/15/2000	3/08/2001	Dr. Aycoth / B-reader	1/1
DX 2	3/16/2000	3/16/2000	Dr. Dahhan / B-reader	Negative
DX 2	3/16/2000	4/03/2000	Dr. Wiot / B-Reader, BCR	Negative

PULMONARY FUNCTION TESTS

Exhibit/ Date	Co-op./ Undst./ Tracings	Age/ Height[37]	FEV_1	FVC	MVV	FEV_1/ FVC	Qualifying Results	Comments
DX 2 3/15/2000	Good/ Good/Yes	52/67	1.63 1.79*	2.88 3.09*	62 76*	57 58*	Yes Yes	Invalid due to inconsistent effort according to unknown doctor (handwriting illegible)[38]
DX 2 3/16/2000	Good/ Good/Yes	52/65.75[39]	1.59 1.64*	2.42 2.56*	64 67*	65 64*	Yes Yes	
DX 2 5/23/2000		52/67	1.56 1.75*	2.64 2.94*	63 78*	59 60*	Yes Yes	Invalid according to Dr. Bruki because "paper speed too slow" – equipment does not meet specifications

* Indicates Post-Bronchodilator Values

[36] As the evidence contained within the original claim filed in 1992 is over ten years old, it is incorporated herein by reference only, except where specifically cited by Claimant or Employer. (DX 1). The evidence contained in the second claim is more recent and therefore more probative. Therefore, it shall be outlined in this opinion.

[37] The fact finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). As the three reports show varying heights from 67 to 65.75 inches, I will use the most common finding and find the Miner's height to be 67 inches for purposes of these tests.

[38] Because I cannot identify the doctor who opined that these tests were invalid – I accord his report no weight. Thus, absent evidence to the contrary, I find these tests to be valid.

[39] Dr. Dahhan listed Claimant's height at 167cm – which is equivalent to 65.75 inches. In his narrative report, Dr. Dahhan stated he considered Claimant to be 66 inches tall. (DX 2).

ARTERIAL BLOOD GAS STUDIES

Exhibit	Date	pCO_2	pO_2	Qualifying	Comments
DX 2	3/15/2000	41 46*	67 54*	No	
DX 2	3/16/2000	44.2 45.9**	71.1 74.1**	No	

* Indicates Post-Exercise
**Exercise was terminated due to fatigue

Narrative Reports

Dr. Rasmussen examined Claimant on March 15, 2000. (DX 2). He considered the following: age of fifty-two years; nineteen years of coal mine employment where Claimant last worked as a belt man;[40] a family history of high blood pressure, heart disease, diabetes, and cancer; a personal history of frequent colds, pneumonia (1988), attacks of wheezing, chronic bronchitis, arthritis (in shoulders, elbows, knees, and legs), and allergies; a smoking history of thirty-five pack years, quitting in 1999; symptomology of sputum, wheezing (worse at night & with exposure to perfumes), twenty plus years of dyspnea, cough, chest pain (sharp pain with exertion) orthopnea, and paroxysmal nocturnal dyspnea; physical examination revealing normal breath sounds with no rales, rhonchi or wheezes; and objective testing, x-ray (1/0),[41] PFT (moderate, irreversible obstructive ventilatory impairment), and ABG (marked hypoxia with moderate exercise). After examining all the evidence, Dr. Rasmussen diagnosed clinical pneumoconiosis resulting from coal dust exposure and chronic bronchitis resulting from coal dust exposure and cigarette smoking (legal pneumoconiosis). Based on the severity of these pulmonary impairments, Dr. Rasmussen opined that Claimant was totally and permanently disabled and lacked the pulmonary capacity to return to his former coal mine employment or employment of similar arduous manual labor in a dust-free environment.

Dr. Dahhan examined Claimant the next day on March 16, 2000. (DX 2). He considered the following: age of fifty-two years; nineteen years of coal mine employment as an underground belt line worker, ending in 1991; personal history of a removal of a tumor from the left cervical area as a child and a cardiac catheterization a few years ago; physical examination showing good air entry to both lungs, but with scattered bilateral expiratory wheezes accompanied by prolongation of the expiratory phase; objective testing including x-ray (negative), PFT (moderate obstructive ventilatory defect), and ABG (minimum hypoxia). Based on these studies, Dr. Dahhan stated that there was insufficient data to justify the diagnosis of coal workers' pneumoconiosis. Specifically, Dr. Dahhan pointed to the obstructive nature shown on the clinical examination of the chest, adequate blood gas exchange, obstructive abnormality on the PFT, and negative x-ray reading to support his conclusion. Based on this testing, Dr. Dahhan stated that Claimant does not have the physiological capacity to continue his previous coal mining work or a job of comparable physical demand in a dust free environment. Dr. Dahhan

[40] This is based on coal mine employment from 1966-1991. Dr. Rasmussen listed his job duties to include shoveling, rock dusting carrying fifty pound bags up to 200 feet, heavy lifting of belt parts, breaking of rocks. In conclusion, Dr. Rasmussen classified this employment as "considerable heavy and some very heavy manual labor."
[41] This x-ray was interpreted by Dr. Manu Patel – who is BCR and a B-reader.

concluded by stating that Claimant's COPD did not result from coal dust exposure or pneumoconiosis. He based this on the fact Claimant had no exposure to coal dust since 1991 – thus any industrial bronchitis he may have had would have ceased by this point. Furthermore, he stated that his obstructive ventilatory defect is treatable with bronchodilators – thus Claimant's impairment is inconsistent with the permanent adverse effects of coal dust.

Pneumoconiosis

In establishing entitlement to benefits, Claimant must initially prove the existence of pneumoconiosis under § 718.202. Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994). Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
>
> (2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

§§ 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

(1) Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. The record contains four newly submitted chest x-rays and two older chest x-rays.[42]

The first x-ray dated March 15, 2000 was interpreted by Drs. Patel and Aycoth to be positive. The same film was interpreted by Drs. Sargent and Barrett to be negative. Drs. Patel, Sargent, and Barrett are equally qualified as BCR and B-readers, and Dr. Aycoth is a B-reader. I find the negative reading by the two dually qualified readers more persuasive. Thus, I find the March 15, 2000 film to be negative for pneumoconiosis.

The second x-ray, which is dated March 16, 2000, was interpreted to be negative by Drs. Dahhan and Wiot.[43] As there is no contrary interpretation of the x-ray, I find it to be negative.

Considering the new x-ray evidence, the first x-ray dated July 29, 2003 was read to be positive by Drs. Forehand and Alexander.[44] Dr. Wiot read the x-ray to be negative. I find the positive reading by Drs. Forehand and Alexander to be more persuasive than the single negative reading by Dr. Wiot. Therefore, I find the July 29, 2003 x-ray to be positive for pneumoconiosis.

The second x-ray dated September 18, 2003 was read as negative by Dr. Wiot. Since there are no contrary readings, I find this x-ray to be negative for pneumoconiosis.

The third x-ray dated March 29, 2004 was read by Dr. Patel to be positive for pneumoconiosis. As there are no contrary readings, I find this x-ray to be positive for pneumoconiosis.

The fourth and final x-ray dated November 25, 2005 was read by Dr. Wiot to be negative for pneumoconiosis. However, Dr. Wiot found that the film was "quality 3." If a film's quality is poor or unreadable, then the study may be given little or no probative value as it is very poor quality. *Gober v. Reading Anthracite Co.*, 12 B.L.R. 1-67 (1988). Since Dr. Wiot, a highly credentialed reader, found this x-ray to be quality three, I accord it no weight for determining the existence of pneumoconiosis.

Here, I have found the two x-rays from the second claim to be negative. In the more recent claim, I have found two of the x-rays to be positive, only one of them to be negative, and one of them received no weight. I find the more recent x-rays to be more probative of Claimant's current condition. Thus, I find that the preponderance of the chest x-ray evidence establishes the existence of pneumoconiosis. Therefore, I find that Claimant has established the presence of pneumoconiosis under subsection (a)(1).

(2) Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. The evidentiary record does not contain any biopsy evidence. Therefore, I find that the Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

---

[42] The x-rays in the first claim are all over ten years old. As such, I find them to have little value in determining Claimant's present condition and accord them no weight.

[43] Dr. Wiot is BCR and a certified B-reader, while Dr. Dahhan is listed as a B-reader.

[44] As noted above, Dr. Forehand is a B-reader, and Dr. Alexander is BCR and a B-reader.

(3) Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

(4) The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 is set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co*., 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director*, OWCP, 7 B.L.R. 1-860 (1985).

Dr. Rasmussen examined Claimant on March 15, 2000 and opined Claimant had pneumoconiosis. Dr. Rasmussen considered Claimant's personal history, employment history, smoking history, a positive x-ray reading by Dr. Patel, PFT, ABG, and physical examination. Based on all this evidence, Dr. Rasmussen concluded Claimant suffered from clinical pneumoconiosis. I find the evidence Dr. Rasmussen considered supports this conclusion. As such, I find his opinion well reasoned and well documented and accord it probative weight.

Dr. Dahhan examined Claimant on March 16, 2000 and opined there is not enough data to justify the diagnosis of coal workers' pneumoconiosis, only COPD. He based this on a few factors. First, he relied upon the obstructive nature of Claimant's pulmonary impairment, as shown in the PFT testing he conducted. He also relied upon his negative x-ray reading. Dr. Dahhan also relied upon how claimant's obstructive pulmonary impairment was "treatable" through the use of bronchodilators. Specifically, he stated the PFT "finding is inconsistent with the permanent adverse affects of coal dust on the respiratory system." While Claimant's PFT testing in fact showed reversibility in this instance, he failed to address how Claimant's PFT testing *post* bronchodilators were still qualifying under the regulations – which indicates an

underlying, permanent, irreversible pulmonary impairment. Furthermore, Dr. Dahhan stated that Claimant's lack of coal dust exposure since 1991 is a "duration of absence sufficient to cause cessation of any industrial bronchitis that he may have had."

The basic premise underlying 20 C.F.R. §725.309 (2000) and (2001) is that pneumoconiosis is a progressive and irreversible disease. § 718.201(c). *See also Mullins Coal Co. of Virginia v. Director, OWCP*, 483 U.S. 135 (1987), *reh'g. denied*, 484 U.S. 1047 (1988) (where the Supreme Court stated that pneumoconiosis is a "serious and progressive pulmonary condition."); *and see Peabody Coal Co. v. Odom*, 342 F.3d 486 (6th Cir. 2003) (pneumoconiosis is a progressive and latent disease which "can arise and progress even in the absence of continued exposure to coal dust"). Here, Dr. Dahhan failed to acknowledge that pneumoconiosis can arise after exposure to coal dust has ceased. As such, I find his diagnosis in regard to clinical pneumoconiosis unreasoned and accord it little weight.

For purposes of legal pneumoconiosis, Dr. Dahhan failed to articulate that even though the PFT was reversible – it failed to bring the results above qualifying, even after the administration of bronchodilators. Thus, he did not address the fixed, underlying, pulmonary condition. In *Consolidation Coal Co. v. Swinger*, the Fourth Circuit Court of Appeals upheld an administrative law judge's finding that the reversibility of pulmonary function values after the use of a bronchodilator does not preclude the presence of coal workers' pneumoconiosis. *Consolidation Coal Co. v. Swinger*, Case No. 03-1971 (4th Cir. May 11, 2004) (unpub.). In addition, in *Cannelton Industries, Inc. v. Frye*, the Fourth Circuit concluded that the administrative law judge properly accorded less weight to the opinion of Dr. Forehand, who found that the miner was totally disabled due to smoking-induced bronchitis, but failed to explain "how he eliminated (the miner's) nearly thirty years of exposure to coal mine dust as a possible cause" of the bronchitis. In affirming the administrative law judge, the court noted that "Dr. Forehand erred by assuming that the negative x-rays (underlying his opinion) necessarily ruled out that (the miner's) bronchitis was caused by coal mine dust …" *Cannelton Industries, Inc. v. Frye*, Case No. 03-1232 (4th Cir. Apr. 5, 2004) (unpub). Moreover, in *Crockett Collieries, Inc. v. Barrett*, the Six Circuit agreed with the Administrative Law Judge's weighing of the medical evidence and affirmed the claimant's award of benefits, noting that:

> In rejecting Dr. Dahhan's opinion, the ALJ found that Dr. Dahhan had not adequately explained why Barrett's responsiveness to treatment with bronchodilators necessarily eliminated a finding of legal pneumoconiosis, and had not adequately explained 'why he believes that coal dust exposure did not exacerbate (the miner's) allegedly smoking-related impairments.'

Crockett Collieries, Inc v. Barrett, 478 F.3d 350, 358 (6th Cir. 2007) (J. Rogers, concurring).

Here, Dr. Dahhan failed to adequately articulate the significance of Claimant's responsiveness to bronchodilators, particularly because Claimant's improved results are still qualifying under the regulations. Additionally, he did not adequately explain why he believes that coal dust exposure did not contribute to Claimant's impairment. Dr. Dahhan failed to

address Claimant's underlying fixed condition, as demonstrated by his own PFT testing. As such, I find this opinion to be unreasoned on the issue of legal pneumoconiosis and accord his opinion little weight.

Dr. Rasmussen examined Claimant on February 26, 2001 and diagnosed Claimant with clinical pneumoconiosis. In coming to this conclusion, Dr. Rasmussen relied upon his physical examination, which included a treadmill stress test, PFT, ABG, employment history, personal history, and an x-ray. However, Claimant did not submit this x-ray for consideration in this claim. In *Keener v. Peerless Eagle Coal Co.*, 23 B.L.R. 1-___, BRB No. 05-1008 BLA (Jan. 26, 2007) (en banc), the Board emphasized that a medical opinion must be based on evidence that is "properly admitted" in a claim. If a report is based on evidence not admitted in the claim, then the administrative law judge must "address the impact of § 725.414(a)(2)(i), (a)(3)(i)." The Board noted that the administrative law judge has several options in handling a report based, in part or in whole, on evidence not admitted in the claim such as excluding the report, redacting the objectionable content, asking the physician to submit a new report, or "factoring in the physician's reliance upon the inadmissible evidence when deciding the weight to which his opinion is entitled." The Board specifically stated, however, that "exclusion is not a favored option, because it may result in the loss of probative evidence developed in compliance with the evidentiary limitations." *Id.*

Here, Dr. Rasmussen relied in some degree upon the positive x-ray reading in arriving at his diagnosis. However, Dr. Rasmussen also relied upon other objective evidence in coming to his conclusion, unlike the case in *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47 (2004)(en banc) where the physical relied explicitly upon the x-ray in coming to his diagnosis. As such, since his diagnosis did not hinge on the x-ray, but his conclusion was simply reinforced by it, I find his opinion well reasoned and well documented. However, since he did rely upon the unadmitted x-ray, I only accord his opinion regarding clinical pneumoconiosis some weight.[45]

Dr. Forehand examined Claimant on July 29, 2003 and opined Claimant had both clinical and legal pneumoconiosis. Regarding clinical pneumoconiosis, Dr. Forehand based his opinion on objective testing, such as the x-ray, and ABG, Claimant's personal history, as well as the physical examination. His determination regarding clinical pneumoconiosis is supported by objective evidence – and he articulated how he relied upon this evidence. Dr. Forehand's description of Claimant's smoking history as well as his occupational history is accurate. As such, I find his opinion both well reasoned and well documented on this issue and accord it probative weight.

---

[45] The parties may feel as though it is unfair to discredit a physician's opinion where he relies upon evidence outside the scope of § 725.414, especially since attorneys may not decide what evidence to designate for submission until the hearing. However, in *Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-98 (2006)(en banc)(J. McGranery and J. Hall, concurring and dissenting), the Board held that a physician's medical opinion must be based on evidence that is admitted into the record in accordance with 20 C.F.R. § 725.414. In articulating its reasoning, the Board stated that "[w]ithin this new regulatory framework, requiring an administrative law judge to fully credit an expert opinion based upon inadmissible evidence could allow the parties to evade both the letter and the spirit of the new regulations by submitting medical reports in which the physicians have reviewed evidence in excess of the evidentiary limitations."

Regarding legal pneumoconiosis (chronic bronchitis), Dr. Forehand based his opinion on Claimant's personal and professional history, the PFT study, and his physical examination. As Dr. Forehand clearly articulated his opinion and relied upon objective evidence in drawing this conclusion, I find his opinion both well reasoned and well documented on this issue and accord it probative weight.

Dr. Jarboe examined Claimant on September 18, 2003 and opined that there was a lack of sufficient evidence to make a diagnosis of coal workers' pneumoconiosis. Dr. Jarboe primarily relied upon two x-ray readings in coming to this conclusion. First, he relied upon his own negative reading of the x-ray taken on September 18, 2003. I note his reading of this x-ray is not admitted under § 725.414. *See Harris*, 23 B.L.R. 1-98, where the Board noted that to give a physician full weight when he considers evidence outside the scope of § 725.414 would allow parties to evade "both the letter and the spirit of the new regulations by submitting medical reports in which the physicians have reviewed evidence in excess of the evidentiary limitations." Furthermore, he relied upon Dr. Forehand's reading of the July 29, 2003 x-ray, which was a reading of 1/0. Dr. Jarboe stated Dr. Forehand considered it a "negative diagnosis." This is incorrect. A reading of 1/0 is considered positive for a finding of pneumoconiosis under § 718.102(b). As Dr. Jarboe relied upon evidence not admitted within the provisions of § 725.414 and misunderstood Dr. Forehand's x-ray reading (which supports a finding of clinical pneumoconiosis), I find that there is no objective evidence for him left to rely on to state Claimant does not suffer from clinical pneumoconiosis.[46] Had Dr. Forehand's x-ray in fact *been* negative, this still would not be reason enough to make a negative diagnosis. *See Mountain Clay, Inc. v. Spivey*, 172 Fed.Appx. 641, 645 (6th Cir. 2006)(citing *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000) articulating that a negative x-ray reading cannot be the sole reason for diagnosing the absence of pneumoconiosis. As such, I accord his opinion no weight for purposes of determining if Claimant suffers from clinical pneumoconiosis.

Concerning legal pneumoconiosis, Dr. Jarboe stated that the physiological evidence in this case does not support a diagnosis of a dust induced lung disease. His main basis for this reason again appeared to be reliance upon the x-rays. While he diagnoses COPD and pulmonary emphysema, he specifically stated that pulmonary emphysema present in coal miners is proportionate to dust retention in the lungs – and the radiographic evidence in this case showed none. Again, consideration of his own x-ray is outside the limitations of § 725.414. *See comments on Harris, infra*. The other x-ray he considered to be negative was in fact positive. Second, Dr. Jarboe stated that Claimant's increase in residual volume could only be explained by cigarette smoking. However, he stated that coal dust exposure can cause an increase in residual, just not as much as seen here in the Claimant. This reasoning does not account for the possibility that both cigarette smoking *and* coal dust exposure combined for the increase in residual volume. Thus, not only is this opinion undocumented for reliance upon unadmitted x-rays, it is also unreasoned for misinterpreting an x-ray and for not accounting for the possibility of coal dust in increase to the residual volume. As such, I find Dr. Jarboe's opinion to be undocumented and unreasoned and accord it only little weight.

[46] In stating there was not enough evidence to diagnose clinical pneumoconiosis, Dr. Forehand only stated this lack of support was the negative x-ray readings. He stated no other objective evidence which would lead a physician to conclude the absence of clinical pneumoconiosis.

Dr. Jarboe testified through deposition regarding his report and review of the medical evidence.[47] Throughout his testimony, he points to radiographic evidence to demonstrate the absence of clinical pneumoconiosis. First, I note that radiographic images alone are not enough to make a negative diagnosis of pneumoconiosis. *Mountain Clay*, 172 Fed.Appx. at 645. Second, Dr. Jarboe mainly relies upon three pieces of radiographic evidence here: his x-ray dated September 18, 2003, which is not in the record; Dr. Forehand's x-ray report which he thought (incorrectly) Dr. Forehand read as negative; and the CT scan taken in 1994 located at DX 1. As his own x-ray is not in the record, Dr. Forehand's was in fact positive, and the CT scan is over ten years old, there is no objective evidence for him to rely on to make this conclusion.[48] Thus, I find Dr. Jarboe's testimony regarding clinical pneumoconiosis is neither well reasoned nor well documented. As such, I accord it little weight.

Regarding legal pneumoconiosis, Dr. Jarboe reiterated the beliefs he articulated in his original report, even in light of the new evidence. He cited the reversibility of Claimant's PFT tests, but failed to note that even after bronchodilators were administered, that the results were often still qualifying, indicating a fixed, underlying impairment.[49] He also focused on the elevation in lung volumes – which is indicative of emphysema. But, because he believed "there was no radiographic evidence of the disease," he opined the emphysema was solely the result of smoking and not coal dust exposure. This opinion is based on reliance of unadmitted x-rays, a misinterpreted x-ray, a ten year old CT scan, and with the understanding that if pneumoconiosis does not show up shortly after a miner leaves the mines, it is non-existent.[50] Because of this, I find Dr. Jarboe's opinion unreasoned and undocumented. As such, I accord his opinion regarding legal pneumoconiosis little weight.

Dr. Rasmussen examined Claimant on March 29, 2004 and opined Claimant suffered from clinical pneumoconiosis. This was based on a positive x-ray reading by Dr. Patel, a correct smoking and employment history, personal history, PFT, ABG, and physical examination. Dr. Rasmussen's conclusions are supported entirely by the objective evidence he considered. Thus, I find his opinion on the issue of clinical pneumoconiosis well reasoned and well documented and accord it probative weight.

Here, I have found many medical opinions diagnosing both clinical and legal pneumoconiosis through a reasoned medical opinion. The only opinions that opines to the contrary are those of Drs. Dahhan and Jarboe. As I have accorded all these opinions little weight for, *inter alia*, failing to recognize the progressive nature of pneumoconiosis, I am more persuaded by the numerous reports that diagnose the presence of legal and clinical pneumoconiosis, all of which are well reasoned and well documented. Therefore, I find that the Claimant has established the presence of pneumoconiosis by a preponderance of the evidence under subsection (a)(4).

---

[47] I noted above I considered the three depositions as one complete testimony of Dr. Jarboe.

[48] I note a CT scan, given the progressive nature of pneumoconiosis, cannot be of much probative value when the scan is over ten years old.

[49] For instance, the results of Dr. Rasmussen's May 23, 2000 and February 26, 2001 PFT results, among others, were specifically noted by Dr. Jarboe.

[50] This is based on Dr. Jarboe's statement that Claimant had been out of the coal mines since 1990. Thus, if Claimant were to develop pneumoconiosis, he would have done so years ago. (EX 3).

Claimant has established the presence of pneumoconiosis under subsection (a)(1) and (4). Therefore, I find that Claimant established pneumoconiosis under § 718.202(a).

Causation of Pneumoconiosis

Once pneumoconiosis has been established, the burden is upon the Claimant to demonstrate by a preponderance of the evidence that the pneumoconiosis arose out of the miner's coal mine employment. 20 C.F.R. § 718.203 (2003).

If a miner suffers from pneumoconiosis and was employed ten years or more in the Nation's coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b); *Stark v. Director,* OWCP, 9 B.L.R. 1-36 (1986); *Hucker v. Consolidation Coal Co.*, 9 B.L.R. 1-137 (1986). As I have found that Claimant has established seventeen years of coal mine employment, if I had found that he suffered from pneumoconiosis, he is entitled to the rebuttable presumption set forth in § 718.203(b) that his pneumoconiosis arose out of his coal mine employment. Here, every doctor who diagnosed Claimant with pneumoconiosis opined it was the result, at least in part, of coal dust exposure. Employer has presented no evidence to the contrary.[51] Therefore, since Claimant is entitled to the rebuttal presumption under § 718.203(b), and Employer has failed to rebut that presumption, I find there is causation.

Total Disability Due to Pneumoconiosis

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a prima facie finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to section 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. Section 718.204(a); *Jewell Smokeless Coal Corp. v. Street,* 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

It has already been decided, and every doctor opined, that Claimant was totally disabled. Everyone agreed that Claimant's current pulmonary condition rendered him unable to return to his former coal mine employment, or employment of equal quality in a dust free environment. Drs. Dahhan and Jarboe opined that this total disability was the result of COPD or emphysema which resulted from cigarette smoking. However, I found their etiology of Claimant's pulmonary impairment to be unreasoned and undocumented. Drs. Rasmussen and Forehand both opined that Claimant's total disability was the result of a combination of coal dust exposure and cigarette smoking.[52] Their etiological findings are based both upon physical examinations and

[51] Drs. Dahhan and Jarboe found that Claimant did not suffer from pneumoconiosis.
[52] Dr. Rasmussen made this conclusion through the results of three different examinations.

objective evidence. Dr. Forehand specifically stated that had Claimant never stepped into a coal mine, Claimant's respiratory impairment would be of a lighter degree. Dr. Rasmussen stated that Claimant's totally disabling lung disease was the result of both a lengthy smoking habit as well as coal dust exposure. Here, I am more persuaded by the opinions of Drs. Rasmussen and Forehand, as they in fact found pneumoconiosis and relied upon objective evidence in drawing their conclusions on this issue.

Thus, I find Claimant does not retain the functional respiratory capacity to return to his last coal mining job or one of comparable and gainful work.

Entitlement

Claimant established a material change in conditions sufficient to meet the statutory requirements of § 725.309(d), and he proved that he suffers from pneumoconiosis and that he is totally disabled due to pneumoconiosis. Therefore, Claimant is entitled to benefits under the Act.

Attorney's Fees

No award of attorney's fees for services to B.B. is made herein, since no application has been received from counsel. A period of 30 days is hereby allowed for Claimant's counsel to submit an application, with a service sheet showing that service has been made upon all parties, including Claimant. The parties have 10 days following receipt of any such application within which to file their objections. The Act prohibits the charging of any fee in the absence of such approval. *See* §§ 725.365 and 725.366.

ORDER

IT IS ORDERED that the claim of B.B. for benefits under the Act is hereby GRANTED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

NOTICE OF APPEAL RIGHTS

Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this decision, by filing notice of appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013- 7601. *See* 20 C.F.R. §§ 725.478 and 725.479. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).